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Pay for performance and health-care reform

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The rumble that we hear is the health-care reform train fast approaching. Scrutiny of current trends and experimental projects indicates that payment methodologies in the future will be based at least in part on quality of performance by providers, with performance defined not only along the lines of clinical parameters and outcomes, but also by efficient utilization of resources. Essential elements for the success of these programs include identification of relevant and valid performance measures, correct data capture and attribution, appropriate benchmarking, and timely and accurate feedback to providers.

> "It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change."—Charles Darwin

Background

A decade has passed since the Institute of Medicine issued a call for aligning payment incentives for providers with a national program to improve the quality of health care.[1] Linking payment to performance has occurred across many kinds of industry; however, pay-for-performance (P4P) has only recently become a viable concept in efforts to improve quality and decrease costs of health care. P4P is the idea that payment to health-care providers should be based on the quality of services provided, patient safety, and effectiveness of care, rather than the volume of services alone. In 2005, Congress mandated that the secretary of the Department Health and Human Services (HHS) develop a plan for value-based payments (VBP) for hospital services provided to Medicare beneficiaries. In October 2012, for the first time, we will see a historic change in the way providers are paid by the Centers for Medicare & Medicaid Services (CMS) because hospitals will receive payment for inpatient acute-care services based on quality. CMS estimates savings of $850 million in Medicare payments to hospitals in 2013 through this program, largely through strategies of reducing hospital-acquired conditions (HAC) and readmissions that result from preventable complications that occur during transition of care.

The recent landmark laws may be the most important health-care legislation to be introduced in the United States since the inception of Medicare in 1965. First, in 2009, the Health Information Technology for Economic and Clinical Health Act was passed as part of the American Recovery and Reinvestment Act. Through this legislation, $25 billion in funding and incentives is slated for health-care providers to stimulate the implementation of health information technology between 2010 and 2015. The second major legislation represents "once-in-a-generation" changes to the U.S. health-care system.[2] In March 2010, President Obama signed into law the legislation that will affect nearly everyone providing, receiving, or financing health care for the next quarter of a century and during the remainder of our professional careers.[3] The provisions of the 2010 Patient Protection and Affordable Care Act (PPACA) are intended to increase access to health care, incentivize coordination and quality in health-care delivery, increase information available for clinical decision making, and provide the system with the tools needed to make decisions about value. The major provisions of PPACA are summarized in Table 1.

While these programs have collectively waded CMS waist deep into P4P, the private sector has taken the

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Table 1 Major provisions of the Patient Protection and Affordable Care Act (PPACA)*

Section	Subject	Description
1001	Health care for dependents	Requires that a health insurance plan make available dependent coverage of children until attainment of 26 years of age
1101	Access to health care for uninsured	The Pre-Existing Condition Insurance Plan (PCIP) makes health insurance available to individuals with preexisting conditions (eg, diabetes, asthma, cancer, HIV/AIDS) that may make private health-care insurance unaffordable. Nearly 32,000 individuals were insured by PCIP on 31 July 2011. By 2014, these patients should transition to options either through their employer or through exchanges that will be more affordable. Insurers will be prohibited from charging more or denying coverage to individuals based on these conditions.
1311	Affordable health benefits	Establish health insurance exchanges; information provided on excessive or unjustified premium increases; states may elect to provide plan management, consumer assistance, or both.
1511-15	Employer responsibility	Employers with 50 or more full-time employees will be subject to penalties for not offering qualifying coverage to full-time employees. Employers with more than 200 full-time employees and who offer employees enrollment in 1 or more health benefit plans must automatically enroll all new employees in 1 of the insurance plans and must continue the enrollment of current employees in a health benefits plan offered through the employer. Employers who do not comply with certain rules will be subject to an annual penalty equal to ~$2000 per full-time employee. Employers must file a return providing specific information concerning health insurance benefits provided to full-time employees.
1421	Small-business tax credit	Small businesses are eligible for Federal tax credits up to 35% of the cost of coverage for their workers (up to 50% by 2014).
2702	Health Care-Acquired Conditions (HCACs)	Requires the secretary of the Department of Health and Human Services (HHS) is to identify current state practices that prohibit payment for HCACs, to incorporate the appropriate practices into regulations, and to prohibit payments to states for any amounts expended for providing medical assistance for HCACs specified in regulations.
2704	Bundling	Requires the secretary of the HHS to establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care with respect to an episode of care that includes a hospitalization and for concurrent physician services provided during a hospitalization.
2718	Decrease costs for coverage	Insurers are required to meet a medical loss ratio standard to spend at least a certain proportion of premium dollars on health care and quality-improvement activities (else reduce premiums or pay rebate to consumers/employers).
3001	Hospital value-based purchasing (VBP)	The secretary of the HHS is required to establish a VBP program whereby incentive payments are made to hospitals that meet certain performance standards during that fiscal year. Demonstration projects include measures obtained from 5 conditions and procedures (acute myocardial infarction, congestive heart failure, pneumonia, surgical care improvement project, and health-care-associated infections) and from the Hospital Consumer Assessment of Healthcare Providers and Systems survey. In 2014, VBP will include adjusted efficiency measures based on Medicare spending per beneficiary. Payments will be based on a base-operating diagnosis-related group AQ:AUTHOR: Please confirm that “diagnosis-related group” is correct as spelled out for DRG and amend if necessary.payment and a VBP incentive percentage.
3002	Physician Quality Reporting System	Professionals able to receive Medicare payment, including allied health-care providers, who do not comply with reporting requirements, will have their payments reduced. For 2015, the penalty for failure to submit data is a reduction in payment to 98.5% of the fee scheduled amount, and for 2016 and subsequent years the penalty is a reduction to 88% of the fee-scheduled amount. Reporting can also be accomplished through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets certain criteria. The maintenance of certification provisions apply for years after 2010. Not later than 1 January 2012, HHS must develop a plan to integrate reporting on quality measures and electronic health record reporting related to the meaningful use of electronic health records.